Psychosocial Care of Babies and Young Children Living with HIV and AIDS
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Acknowledgements

Cotlands wishes to thank the following people for their dedicated assistance in the research, development and implementation of this learning programme:

From Cotlands
Bonnie Haack  HR, Training and Development Director
Busi Nkosi  Outreach Manager
Crystal Smit  Research and Development
Faith Madiehe  Residential Care Manager
Girly Hleza  Training Officer and Skills Development Facilitator
Jackie Schoeman  Executive Director
Jade Freedman  Training Administrator
Lyndsay Barr  Social Work
Mealang van Heerden  HOD Educare
Mmatsie Mpshane  Training Manager
Petunia Tsotetsi  Social Work
Stella Dubazana  Childcare Manager
Thembi Gutyungwa  Child Development Co-Coordinator

From the Department of Health
Michelle Bester  Comprehensive HIV and AIDS Care, Management, Treatment and Support Plan for Children
   Directorate: Child and Youth Health
Ntombi Mazibuko  Comprehensive HIV and AIDS Care, Management, Treatment and Support Plan for Children
   Directorate: Child and Youth Health

From UNICEF
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# How to use this guide

<table>
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<tr>
<th>Icon</th>
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<tbody>
<tr>
<td><img src="image" alt="Group activity or discussion" /></td>
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<td><img src="image" alt="Small group activity" /></td>
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<td><img src="image" alt="Individual activity" /></td>
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<td><img src="image" alt="Skills practice" /></td>
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Background information

The comprehensive approach to the challenge of HIV and AIDS implies a broad spectrum of appropriate interventions. The HIV and AIDS and STI National Strategic Plan 2007–2011 Goal No. 7 aims at addressing the special needs of pregnant women and children. The objective is to provide a comprehensive package of services that includes wellness, care and ART to HIV-infected, -affected and -exposed children and adolescents. Providing psychosocial support for children has been identified as one of the interventions towards achieving the objective of providing a comprehensive package.

Based on the preceding information, it is therefore imperative to give attention to the psychosocial care of HIV-positive babies and young children.

This manual aims to equip health and child care practices with information and skills for the psychosocial care and support of babies and young children who are living with HIV and AIDS and who are on treatment in the health system.

The manual begins by outlining background information on HIV and AIDS which is essential embedded knowledge for all practitioners working with children. It touches on issues like communicating with children, their developmental milestones and most importantly, the psychosocial impact of HIV and AIDS on young children.

Always review the latest policies from the Department of Health in preparation for this training.
Welcome and introduction

Aim of this session

The welcome and introduction session aims to introduce trainees and facilitators to one another and to determine the trainees' expectations of the course.

Session plan:

<table>
<thead>
<tr>
<th>Module</th>
<th>Topic</th>
<th>Time</th>
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<tbody>
<tr>
<td>Registration</td>
<td>Welcome and introductions</td>
<td>08:30 – 09:00</td>
</tr>
<tr>
<td>Module 1</td>
<td>Background to HIV and AIDS</td>
<td>9:00 – 09:30</td>
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<td>Module 2</td>
<td>ART criteria and compliance</td>
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<td>Module 3</td>
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<td>10:00 – 10:30</td>
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<td>Module 4</td>
<td>Developmental milestones in children from birth, and the neurological impact of HIV and AIDS on development</td>
<td>10:30 – 11:00</td>
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<td>Tea</td>
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<td>11:00 – 11:30</td>
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<tr>
<td>Module 5</td>
<td>Stimulation and development programmes</td>
<td>11:30 – 12:00</td>
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<td>Module 6</td>
<td>Record-keeping assessments</td>
<td>12:00 – 12:30</td>
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<tr>
<td>Module 7</td>
<td>Psychosocial impact of HIV and AIDS on young children</td>
<td>12:30 – 13:00</td>
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<tr>
<td>Lunch</td>
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<tr>
<td>Module 8</td>
<td>Family and community support systems</td>
<td>13:30 – 14:00</td>
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<tr>
<td>Module 9</td>
<td>Communication with children living with HIV and AIDS</td>
<td>14:00 – 14:30</td>
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<td>Module 10</td>
<td>Counselling and children</td>
<td>14:30 – 15:00</td>
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<td>Final comments and closing</td>
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<td>15:00 – 15:30</td>
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Notes
Module 1: Background to HIV and AIDS

Aims of this module

Module 1 aims to reinforce the trainee's prior knowledge of HIV and AIDS transmission before equipping him or her with the skill to respond to psychosocial care and support required by babies and children living with HIV and AIDS and who receive Antiretroviral Therapy (ART).

Learning outcomes

By the end of this module, the trainee should be able to:
✓ Demonstrate an understanding of the differences between HIV and AIDS
✓ Describe the transmission of HIV
✓ Role play how the immune system of a child living with HIV and AIDS becomes deficient
✓ Demonstrate an understanding of how adults and infants progress from HIV to AIDS.

Further reading
1.1 Activity – Assessment of essential embedded knowledge

**Aim:** To determine trainee’s prior knowledge of course content

Notes

1.2 Activity – Progression from HIV to AIDS

**Aim:** To allow learners to discover how HIV progresses to AIDS

Notes
1.3 Activity – Resolving misconceptions

Aim: To allow time for questions and resolution of any misconceptions

Notes


### Adult

**Stage: Primary phase/acute sero-conversion illness**

- 30% – 60% of people will develop a glandular, fever-like illness, often mistaken as a bout of flu; signs and symptoms include sore throat, headaches, fever, fatigue, muscle and joint pains, swelling of the lymph nodes, rash and occasional oral ulcers.

### Infant

- The infant seems to progress through the stages more quickly. During the last trimester, the mother passes all her antibodies to the baby for diseases such as measles, chickenpox and HIV. Most babies born to mothers living with HIV and AIDS will initially test positive for HIV antibodies. It is more helpful to look at the baby’s clinical condition (i.e. state of health) during the first year of life.

- As the baby’s own immune system starts to develop and get stronger, the mother’s antibodies are absorbed into the body and disappear. This is called reversion and usually happens within the first ten months of the child’s life. The baby would then be tested using the HIV antibody test.

- If the baby is usually well and gaining weight in the normal way, he or she is unlikely to have the virus. However, if the baby is constantly sick and not thriving, he or she may have been infected with the virus. Children over the age of ten months who are still testing positive will, in all probability, be HIV infected.

### Stage: The asymptomatic latent phase

- Most people living with HIV and AIDS have absolutely no signs or symptoms during this phase. Only a small percentage experience swollen glands (persistent generalised lymphadenopathy).

### Stage: The minor symptomatic phase

- **✓** Mild to moderate swelling of the lymph nodes in the neck, armpits or groin.
- **✓** Occasional fevers.
- **✓** Herpes zoster (shingles).
- **✓** Skin rashes, dermatitis, chronic itchy skin, fungal nail infections.
- **✓** Recurrent oral ulceration.
- **✓** Recurrent upper respiratory tract infections (colds, flu and coughs).
- **✓** Weight loss of up to 10% of the person’s usual body weight.
- **✓** Tiredness, fatigue, lethargy.

- **✓** Failure to thrive – losing or not gaining weight normally.
- **✓** Spiking temperatures – occurring suddenly, with no warning.
- **✓** Skin rashes – seborrhoic dermatitis/eczema.
- **✓** Thrush – both oral and genital.
- **✓** Diarrhoea – may not be continuous at this stage.
- **✓** Developmental delays – delayed milestones.
- **✓** Lactose intolerance – cannot tolerate milk products. Soya substitutes must be used.
- **✓** Discharge – responds to rehydration.
- **✓** Persistent vomiting.
- **✓** Chronic nappy rash.
- **✓** Anaemia resulting in general fatigue.
- **✓** Mouth ulcers.
- **✓** Cold sores, scratches and other superficial wounds that do not heal.
<table>
<thead>
<tr>
<th><strong>Adult</strong></th>
<th><strong>Infant</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Stage:</strong> The major symptomatic phase CD4 count is usually below 350 cells/mm³</td>
<td><strong>Stage:</strong> The major symptomatic phase CD4 count is usually below 350 cells/mm³</td>
</tr>
<tr>
<td>✓ Persistent and recurrent oral and vaginal thrush.</td>
<td>✓ Spiking temperatures and prolonged fevers occurring suddenly, without warning. These are difficult to control.</td>
</tr>
<tr>
<td>✓ Recurrent herpes infections both zoster (shingles) and simplex (fever blisters/cold sores on the mouth).</td>
<td>✓ Lactose intolerance – cannot tolerate milk products. Soya substitutes must be used.</td>
</tr>
<tr>
<td>✓ Bacterial skin infections and rashes.</td>
<td>✓ Severe ongoing and recurring bacterial infection.</td>
</tr>
<tr>
<td>✓ Unexplained fevers and night sweats in the absence of tuberculosis (TB).</td>
<td>✓ Upper respiratory infections.</td>
</tr>
<tr>
<td>✓ Chronic diarrhoea.</td>
<td>✓ Pneumonia (pneumocystis carinii).</td>
</tr>
<tr>
<td>✓ Significant and unexplained weight loss – more than 10% of the body’s usual weight.</td>
<td>✓ Urinary tract infections.</td>
</tr>
<tr>
<td>✓ Generalised lymphadenopathy (swelling of lymph glands).</td>
<td>✓ Meningitis (inflammation of the membranes that cover the brain and spinal cord).</td>
</tr>
<tr>
<td>✓ Abdominal pains and discomfort.</td>
<td>✓ Skin infections and rashes.</td>
</tr>
<tr>
<td>✓ Headaches.</td>
<td>✓ Osteomyelitis (infection of the bone).</td>
</tr>
<tr>
<td>✓ Oral hairy Leukoplakia (white patches).</td>
<td>✓ Chronic tonsillitis, ear infections.</td>
</tr>
<tr>
<td>✓ Eye infections and visual disturbances.</td>
<td>✓ Neurological damage.</td>
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<tr>
<td>✓ Ear infections.</td>
<td>✓ Developmental delay or regression of milestones.</td>
</tr>
<tr>
<td>✓ Persistent cough and reactivation of old TB or evidence of new TB infection.</td>
<td>✓ Poor general muscle tone.</td>
</tr>
<tr>
<td>✓ Reduced head growth.</td>
<td>✓ Seizures and fits.</td>
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<tr>
<td>✓ Seizures and fits.</td>
<td>✓ Twitches and other abnormal neurological abnormalities.</td>
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<tr>
<td>✓ Twitches and other abnormal neurological abnormalities.</td>
<td>✓ Skin sensitivity.</td>
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<tr>
<td>✓ Skin sensitivity.</td>
<td>✓ Enlarged liver, spleen, salivary glands and lymph nodes.</td>
</tr>
<tr>
<td>✓ Repeated thrush – both oral and genital.</td>
<td>✓ Repeated thrush – both oral and genital.</td>
</tr>
<tr>
<td>✓ Diarrhoea – continuous and difficult to treat.</td>
<td>✓ Diarrhoea – continuous and difficult to treat.</td>
</tr>
<tr>
<td>✓ Dehydration – difficult to rehydrate.</td>
<td>✓ Dehydration – difficult to rehydrate.</td>
</tr>
<tr>
<td>✓ TB – infecting lungs and other organs.</td>
<td>✓ TB – infecting lungs and other organs.</td>
</tr>
<tr>
<td>✓ Recurring nappy rash, vomiting and mouth ulcers.</td>
<td>✓ Recurring nappy rash, vomiting and mouth ulcers.</td>
</tr>
<tr>
<td>✓ Discharge from ears and/or nose.</td>
<td>✓ Discharge from ears and/or nose.</td>
</tr>
<tr>
<td>✓ Cold sores, scratches and other superficial wounds that do not heal.</td>
<td>✓ Cold sores, scratches and other superficial wounds that do not heal.</td>
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**Stage: Severe symptomatic phases – AIDS CD4 <200**

- All the above conditions PLUS – PCP (Pneumocystis Carinii Pneumonia), Peripheral Neuropathy (damage to the peripheral nervous system which transmits information from the brain and spinal cord to every other part of the body), AIDS Dementia (decline in mental processes), Cryptococcal Meningitis (a life-threatening brain infection), Kaposi’s Sarcoma (a malignant tumor of the connective tissue), Lymphoma (cancer of the lymph glands), extreme weight loss, continuous diarrhoea, etc.

- Continuous and rapid weight loss – wasting syndrome.
- Little or no appetite (this may be related to thrush or mouth ulcers) which affect the oesophagus and stomach, causing pain and discomfort.
- Continuous diarrhoea resulting in dehydration and dry skin.
- Decreased mobility as a result of fatigue.
- Dry skin as a result of dehydration.
- Pressure sores.
- Prolonged fevers.
- Persistent swollen glands and lymph nodes.
- TB.
- Recurrent bacterial infections.
- Underdeveloped head, smaller than normal for this age.
- Regression of developmental milestones.
- Pain from various infections and organ damage.
Module 2: ART criteria and compliance

Aims of this module

Module 2 aims to:
✓ Provide basic information about ART to community members of similar cultural backgrounds and mother tongue
✓ Facilitate treatment compliance for the child who is receiving ART
✓ Outline factors that promote the success of ART
✓ Explain the psychosocial and cultural factors that have an effect on a child receiving ART.

Learning outcomes

By the end of this module, the trainee should be able to:
✓ Demonstrate a fundamental knowledge of ART and its role in HIV and AIDS
✓ Explain the psychosocial and cultural factors that affect the child receiving ART, the family and the community
✓ Explain the factors that promote the success of ART.

Further reading
✓ Guidelines for management of the HIV-infected child
✓ Soul City literature
✓ Pamphlets at local clinics
✓ Childline literature
2.1 Activity – Administering ART

Aim: To educate the family about the correct way of administering ART

Procedure:
✓ Wash your hands
✓ Measure the prescribed amounts of liquid medication
✓ Dispense the prescribed amounts of capsules into a medicine glass
✓ Administer the medication with food or after eating
✓ Make sure that the medication has been swallowed by politely asking the child to open his or her mouth
✓ Give the child yoghurt, sweets or oranges after the medication to alleviate the bitter taste
✓ Wash, rinse and store utensils according to policies and procedures
✓ Sign or tick the medication chart provided and record any reactions, e.g. vomiting.

Notes


2.2 ART criteria and compliance

Every child living with HIV and AIDS has the right to comprehensive therapy, which includes ART to reduce morbidity and age-related mortality from HIV infection and to improve their quality of life.

What is ART?
• ART comprises a regime of medication that suppresses or prevents the activity of HIV
• This medication disrupts the HIV enzyme’s ability to perform genetic copying and produce a
virus that can infect other cells
• ART is best if it is used in combination with three different medications
• Highly Active Antiretroviral Therapy (HAART) is a combination regimen to reduce the viral load to undetectable levels
• With ART, the CD4 cell count rises and remains above the baseline count.

Treatment of mothers/caregivers or other family members
• Always ask about the caregiver’s health and the health of other family members
• Ensure that mothers and other family members accept medical care, including ART, if needed
• Where possible, mothers and caregivers living with HIV and AIDS should be attended to at the same time as the children in order to decrease the number of clinic visits, costs and absences from work.

Mild side-effects
The side-effects of ART are not life-threatening and treatment should not be stopped if any of the symptoms below occur. These side-effects usually last only two to three days after ART has commenced:
• Mild nausea, vomiting, diarrhoea
• Dizziness
• General malaise, tiredness
• Peripheral neuropathy, pins and needles in hands and feet
• Nail discolouration
• Rash.

Severe side-effects
• Liver damage – lipodystrophy
• Abdominal pain – pancreatitis
• Bone marrow failure
• Lactic acidosis
• Reconstitution illness (infections in therapy); when a person begins therapy, infections which appear to have been cleared from the body will resurface and need to be treated once again.

Benefits of compliance
• Children experience a type of ‘high’ or a feeling of extreme emotional well-being when starting ART
• Their appetite improves
• They gain weight
• They pick up fewer opportunistic infections
• Hope is restored in both parent and caregiver
• Their immune systems are boosted.

Adherence
• The patient must stick to the treatment plan
• The prescribed ART medication must be taken daily at the right time and in the correct dosage
• The patient must meet scheduled medical appointments
• The patient must collect medical repeats.
Consequences of non-adherence
- Building up a resistance to the ART medication
- The virus is free to copy or reproduce itself
- The virus mutates, preventing the medication from working when it is taken again
- Doctors will need to do a viral load test to detect whether or not a high resistance has developed.

2.3 How can we improve the efficacy of ART in children?

To answer this question, we need to look at what makes ART adherence in children difficult.

What makes ART adherence in children generally difficult?
- The child is dependent upon an adult for treatment to be correctly administered
- ART is not a simple regime: the patient needs to take three different medications, twice a day, every day
- Babies cannot swallow pills and must take their medication in syrups; this could be an expensive requirement
- The volume of syrups required is often large
- Some of the ART medications taste bad
- The child may refuse to take the medication
- The child may not understand why he or she needs to take the medication
- The child may spit out or vomit up the medication
- The child may develop side-effects
- The timing of the doses may be difficult for caregivers to adhere to
- Mothers/caregivers may want to hide the fact that the child is on treatment
- Remembering and keeping medical appointments may be difficult
- Medication supply/ordering from pharmacies may be a problem.

In a residential care setting there are different obstacles to overcome, including:
- A multiple caregiver system
- Shift changes, new staff
- Volunteers and host families who accommodate the children over holiday periods
- Hospitalisation of children on ART
- Several children within a family needing ART at the same time
- Timing of dosing may be difficult for caregivers
- Confidentiality/disclosure issues in homes
- Remembering appointments
- Medication supply/ordering from pharmacies.

How can we improve this?
There are a number of ways to improve adherence. These include:

1 Tools that serve as reminders to take medication:
   ✓ Setting alarms on watches and cellphones.
   ✓ Having a ‘treatment buddy’ who phones to remind the patient to take his or her medication.
   ✓ Recording medication that has been administered on a diary card.
   ✓ Packing medication into a weekly pill box.
2 Ways to ensure that the complete dose of drug is ingested:
✓ Pill swallowing should be encouraged from as early as three years of age. A drug given in capsule form is more likely to be completely ingested than a liquid that can be spat out or spilled.
✓ When administering syrups, a syringe is preferable to a spoon because spillage from a teaspoon is potentially greater than from a syringe. If spoons are used, they should be demarcated to accurately measure volumes. Household metal teaspoons often do not contain a full 5 ml. Medicine measures or medicine spoons are preferable.
✓ If a child vomits within 30 minutes of having ingested a medication, it is most likely that the majority of the medication was not absorbed since gastric emptying is not completed in this short time. In this case, the full dose should be repeated. If vomiting occurs more than an hour after ingestion, it is not necessary to repeat the dose.
✓ Poor palatability often affects the completeness of medication ingestion. Infants and young children often spit out a foul tasting medicine. The protease inhibitor Norvir is well known for its poor palatability. Palatability can be improved by administering the medication with chocolate milk, yoghurt or by coating the tongue (i.e. taste buds) and sides of the cheek with peanut butter to decrease contact between the medication and the taste buds.
✓ If spillage occurs or medicines have to be repeated because they were spat out or vomited up, this should be recorded so that extra medication can be acquired before the supply runs out.
✓ If a child on ART is hospitalised, his or her treatment must be taken along to hospital. This is especially important in the case of those hospitals that are not roll-out sites or that do not provide ART.

3 Ways to remember appointments and medication collection days:
✓ Diaries, wall calendars, etc.
✓ Notes stuck to fridges, mirrors, etc.
✓ Cellphone reminders and internal networks (within your organisation).

4 Ways to overcome obstacles in the residential care setting:
✓ One way to maximise ART administration in children’s homes is to have written rules and regulations about the treatment. This could be called the home’s “ART PLAN” or “ART PROTOCOL”. These rules and regulations should include guidelines for volunteers or host families who take children out of the home for weekends and holidays.

2.4 Psychosocial factors and care

_Individuals and families could experience these losses:_
**Financial:** Absenteeism as a result of illness eventually leads to dismissal
**Physical:** Gross loss of weight and physical changes, e.g. ulcers (mouth and face)
**Social:** The sick person may be abandoned or neglected
**Psychological:** The sick person may feel lonely and isolated as a result of the disease

These losses may have a direct impact on the child’s or individual’s motivation and willingness to follow the prescribed treatment.
**Major areas of emotional distress:**

**Discrimination:** Against the child as a result of lack of knowledge about HIV and AIDS

**Stigmatisation:** Diagnosis of HIV infection presents a major crisis and can result in discrimination as there is no cure

**Culture:** Because HIV and AIDS is spread through sexual intercourse, it is not discussed in some households because sex is a taboo subject

**Lifestyle:** The sick person may withdraw socially

**Losses:** Financial, physical and social

**Conflicting emotions:** Feelings of denial, anger, guilt and fear

**Before any intervention, pain should be alleviated by:**

- Administering analgesics regularly.
- Treating and managing all symptoms timeously and appropriately.
- Explaining what the intervention will be like prior to the procedure, if the child is old enough to understand.
- Dealing appropriately with changes in the physical appearance of children; cuddle and touch to make them feel loved; avoiding teasing and mockery.
- Answering all questions honestly.
- Creating an adequate and comfortable child-friendly area where the intervention will take place.
- Offering a variety of toys to distract the child during the intervention.
- Sitting and talking to the child before, during and after the intervention.
- Comforting babies and small children by carrying them on your back using blankets.
- Allowing children to play to help distract them from the intervention.

### 2.5 Visiting in the home or health care facility

Daily home visits will be done after the commencement of treatment. This will allow the caregiver to check for any type of reactions or side-effects the child may be experiencing. The caregiver will also be in a better position to monitor the dosage of medication being administered.

The child will feel more comfortable in their own home/environment; this will enable the caregiver to observe the ‘true’ health of the child. The caregiver should monitor the child’s health, general development, as well as offer support to the family.

Two weeks after starting the ART, the child will need to return to the hospital or health care facility that prescribed the medication. This follow-up appointment monitors the adherence to the medication regime.

Thereafter, monthly visits will be scheduled to ensure medication regimes are followed, and to offer support and advice to the family.
Module 3: Nutrition for children living with HIV and AIDS

Aims of this module

Module 3 aims to provide the trainee with knowledge on the relationship between HIV and AIDS and malnutrition so that he or she can provide good nutrition for a child who is living with HIV and AIDS in a variety of contexts.

Learning outcomes

By the end of this module, the trainee should be able to:

✓ Describe the nutritional needs of a child living with HIV and AIDS
✓ Describe the contributing factors towards malnutrition in children living with HIV and AIDS
✓ Describe the different food groups and their sources
✓ Draw up an appropriate nutritional plan for a child living with HIV and AIDS within a family context or an institution.
3.1 Definition

**Nutrition** is when the body receives healthy foods in the correct quantity to aid and allow the functioning, repair, growth and maintenance of the body. It is the science of nourishing the body properly.

3.2 The nutritional needs of a child living with HIV and AIDS

Children living with HIV and AIDS have increased energy needs compared to uninfected children. The energy needs increase by 10% in asymptomatic children and between 50% and 100% in symptomatic children. These children also experience a deficiency in micronutrients. Nutrition therefore forms an integral part of any care plan for children living with HIV and AIDS. Nutrition is also important in the provision of ART to achieve the full benefits.

**Good nutrition is important because it:**
- Strengthens the body’s protection against diseases and illnesses
- Helps the body recover from diseases and illnesses
- Provides adequate storage of required nutrients
- Helps maintain body weight, muscle thickness and tone
- Assists the body in absorption of medication, thus resulting in positive reactions.

**Maintaining good nutrition can be assisted by:**
- Eating a balanced diet which contains a variety of foods
- Exercising regularly
- Practising food hygiene to prevent infections
- Taking ART reduces the viral load and boosts the immune system.

**To benefit from good nutrition, the child should:**
- Be weighed regularly to ensure there is no sudden drastic drop in weight
- Eat a balanced meal consisting of a variety of foods at least three times a day
- Have new infections or illnesses treated as soon as possible
- Be taught good hygiene practices to prevent the spread of infections.
3.3 Contributing factors towards malnutrition in children living with HIV and AIDS

Malnutrition is a common complication associated with HIV and AIDS. It adds stress to an already weakened immune system and may complicate the treatment of the disease by affecting the intestinal tract’s ability to absorb medication, proteins, carbohydrates and fats.

The following are factors why a child living with HIV and AIDS could become malnourished:

1. Children living with HIV and AIDS have higher nutritional requirements to sustain the different functions and developmental needs of their bodies. Generally, these children have poor food intake due to inadequate food in the home thus increasing the risk of becoming malnourished.

2. As the disease progresses, opportunistic infections worsen, resulting in different symptoms affecting the body. Some of these symptoms are:
   ✓ Sores in the mouth
   ✓ Thrush, which may be present in the mouth and/or oesophagus (throat). It is important to note that thrush may be present in the oesophagus without being present in the mouth
   ✓ Nausea and vomiting
   ✓ Side-effects from medication
   ✓ Diarrhoea, the cause of which may or may not be known
   ✓ Inability to tolerate fats and lactose (milk sugars).

3. Children who are living with HIV and AIDS and on ART can experience a decrease in daily nutritional needs. This is because these children often experience side-effects associated with ART. Some of these side-effects are:
   ✓ Anaemia
   ✓ Allergic reactions
   ✓ Abdominal pain, loss of appetite, nausea, vomiting and constipation or diarrhoea
   ✓ Elevated blood cholesterol
   ✓ Bone marrow suppression
   ✓ Weakness and dizziness
   ✓ Skin reactions and rashes.

Other contributing factors are:

1. Changes in metabolism:
   ✓ Depletion of mineral and vitamin stores
   ✓ Increased use of body stores
   ✓ Changes in the function of the gastrointestinal tract that affect the body’s ability to use food in an efficient way
   ✓ Recurrent fevers and infections causing a rise in metabolic rates.

2. Functional impairment:
   ✓ Chewing and swallowing may be greatly affected in children when HIV has affected their nervous system.
3.4 Intervention strategies

**Sores in the mouth and oral thrush**
- Provide small, frequent meals.
- Provide soft, non-irritating foods, e.g. yoghurt, eggs, soups, custard, etc.
- Avoid food that is spicy, sour or sweet.
- Serve food cold or at room temperature.
- Allow the child to use a straw for drinking so that the fluid does not touch the sore parts of the mouth.

**Nausea and vomiting**
- Encourage the child to drink lots of water as it contains most nutrients and enzymes needed by the body.
- Eating dry toast and rusks may be helpful.
- Encourage the child to eat when he or she feels hungry and not only at set meal times.
- Avoid foods with a high content of fat and a strong aroma.
- Avoid very sweet food.
- Encourage the child not to lie down flat directly after a meal, as this may cause regurgitation.
- Make meals tasty and enjoyable.
- Good oral hygiene is essential.

**Diarrhoea**
- Provide lots of fluids to replace the lost fluid; prepare rehydration fluid.

---

**To make rehydration fluid, use the following:**

1 litre boiled water, allow the water to cool
8 level teaspoons sugar
Half a teaspoon salt

**NB: Prepare fresh rehydration fluid every day**

- Provide small, frequent meals.
- Soya milk is the preferred form of milk, if available.
- Offer rice cereals, pasta, soft porridge, mashed fruits (except pears) and vegetables, boiled or steamed meat.
- Avoid fatty foods.

**Fever**
- Provide plenty of fluids – either cold water, rehydration fluid or any type of clear fluid drink, e.g. rooibos tea with no milk. Rehydration solution is especially important when there is a risk of dehydration.
- The child may not want to eat solid food. However, as soon as the temperature is down, encourage him or her to eat.
- If the child does not want solid food, begin with small quantities of soft foods like porridge and cereal.
**Weight loss**

- Increase the quantity of food provided, as long as the child is able to eat more. However, this may not be enough as the child may still lack certain vitamins and minerals. Nutritional supplements, which increase the appetite and encourage weight gain, can be given (e.g. Progress and Complan). These supplements must be taken under the supervision of a health care provider.
- Encourage the child to eat three regular, well-balanced meals every day, with nutritious snacks between meals.
- If the child will not eat, provide regular nutritious liquid meals.
- Try to make sure that all food given to the child has nutritional value.
- You may also try to include the following in the child’s diet: butter, eggs, sugar, honey, yoghurt, cheese, dried fruit and peanut butter.
- Make meal times relaxed, ensuring the food is tempting and varied.
- Be patient.

### 3.5 Nutritional management

**Different food groups and their sources**

It is important to understand the different food groups and their functions in the body. The body requires different amounts of different foods in order to function properly, although not all nutritional requirements may be met at any particular meal. It is therefore important to formulate and adhere to a well-planned menu.

<table>
<thead>
<tr>
<th>Food group and quantity</th>
<th>Food sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starchy foods</strong></td>
<td>Bread, pap/phuthu/ting, soft porridge, cereals, rice, potatoes, sweet potatoes, samp, millet, mealies, sorghum, pasta, mavhele, corn, umnqusho, sorghum and amadumbe.</td>
</tr>
<tr>
<td>These foods should be included in every meal.</td>
<td></td>
</tr>
<tr>
<td><strong>Fruit and vegetables</strong></td>
<td>Vegetables: spinach, morogo/mifuno, delele, mushidzhi, vowa, pumpkin leaves, green peppers, sweet potatoes, unomxoxozi/ibhece, pumpkin, beetroot and beetroot leaves and carrots.</td>
</tr>
<tr>
<td>Children should eat at least five portions of fruit and vegetables every day.</td>
<td></td>
</tr>
<tr>
<td>Fruit: yellow peaches, apricots, paw-paws and mangoes.</td>
<td></td>
</tr>
<tr>
<td>Citrus fruits like oranges, naartjies, grapefruit, lemons and guavas.</td>
<td></td>
</tr>
<tr>
<td>Mangoes, tomatoes, marula fruit and potatoes supply vitamin C.</td>
<td></td>
</tr>
<tr>
<td>Sweet potato leaves, thanga, dried or fresh pumpkin, unomxoxozi, dandelion, watermelon, idolofiya, uqgumqgumu, umsobo, amarula, semphemphe, mahuhuma, madzidzi and mazwilu.</td>
<td></td>
</tr>
</tbody>
</table>
### Food group and quantity

<table>
<thead>
<tr>
<th>Food Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meat and dairy foods</strong></td>
</tr>
<tr>
<td>These may be eaten on a daily basis.</td>
</tr>
<tr>
<td>Meat: beef, mutton, goat, pork, chicken and fish may be eaten daily.</td>
</tr>
<tr>
<td>Organ meats from animals (liver, kidney, heart and brains), trotters,</td>
</tr>
<tr>
<td>mautuana and tripe (mala mogodu) may be included.</td>
</tr>
<tr>
<td>Eggs, milk, yoghurt, buttermilk, sour milk, milk powder and cheese</td>
</tr>
<tr>
<td>may also be eaten.</td>
</tr>
<tr>
<td>Insects: mopani worms, izinhlwabusi, termites (such as izintethe/nzie);</td>
</tr>
<tr>
<td>grasshoppers should also be included as they provide good protein sources;</td>
</tr>
<tr>
<td>mbiba, unogwaja, rabbits and mbila.</td>
</tr>
<tr>
<td><strong>Dried beans, peas, lentils, peanuts or soya</strong></td>
</tr>
<tr>
<td>To be included regularly.</td>
</tr>
<tr>
<td>Dried beans, peas, lentils, peanuts, peanut butter, jogo beans and soy</td>
</tr>
<tr>
<td>beans, amantonggomane, dhovi, ndhu, izindlubu, dinawa and ditloo.</td>
</tr>
<tr>
<td><strong>Sugar</strong></td>
</tr>
<tr>
<td>To be included especially after infections or periods of weight loss.</td>
</tr>
<tr>
<td>Vetkoek, cakes, pastries, biscuits, cookies, tarts, puddings, desserts and</td>
</tr>
<tr>
<td>magwinya.</td>
</tr>
<tr>
<td><strong>Fats and oils</strong></td>
</tr>
<tr>
<td>To be included daily in moderation.</td>
</tr>
<tr>
<td>Butter, margarine, cooking oils, cream, mayonnaise and salad dressings.</td>
</tr>
</tbody>
</table>

### 3.6 Activity – Menu preparation

**Aim:** To assist the trainees to plan an appropriate diet in relation to the different circumstances encountered by a child living with HIV and AIDS
Module 4: Developmental milestones in children from birth, and the neurological impact of HIV and AIDS on development

Aims of this module
Module 4 aims to develop an understanding and awareness of delays in developmental milestones in children living with HIV and AIDS from birth.

Learning outcomes
By the end of this module, the trainee should be able to:
✓ Demonstrate an understanding of the basic developmental milestones of children from birth to five years
✓ Reflect on the neurological impact of HIV and AIDS on development.

Further reading
✓ Know the pre-school child: Transvaal Education Department
✓ Is your child school ready? by Anna-Marie Wentzel
4.1 Developmental milestones from birth to three months

**Emotional**
- Learns to depend on adults if adults respond to his or her cries
- Feels secure when adults hold him or her in their arms.

**Physical**
- Sucks on fingers or hands because this is soothing
- Moves hands and feet
- Is able to hold his or her head up for a short period of time.

**Social**
- Recognises parents’ voices.

**Language**
- Cries to ‘call’ adults.

4.2 Developmental milestones from three months to six months

**Emotional**
- Responds positively when adults smile at him or her
- Frowns or cries when adults stop paying attention or playing
- Needs comfort when upset or frightened.

**Physical**
- Studies hands and fingers
- Discovers that hands and feet are a part of his or her body
- Smiles often
- Puts hands and objects into his or her mouth
- Is able to roll over
- Has favourite positions but likes change, e.g. to move from being on the back, to lying on the stomach, to sitting up.

**Social**
- Prefers human contact to toys
- Likes being held
- Likes adults to talk softly and to smile.
Intellect
- Likes to look around and see new things.

Language
- Communicates through facial expressions and gestures
- Has different cries, facial expressions and body movements to communicate sleepiness
- Stretches arms out when wanting to be picked up
- Closes eyes or turns head away when losing interest.

4.3 Developmental milestones from six months to nine months

Emotional
- Learns to wait a few minutes when he or she has a need to be met, if secure in the knowledge that adults will always come and attend to his or her needs
- Laughs aloud sometimes with a belly laugh
- Needs to feel protected when feeling overwhelmed
- Is sometimes fussy.

Physical
- Can shake a rattle and make sounds
- Can kick a mobile and make it move
- Smiles and wiggles when an adult plays with him or her
- Can hold something, let it go and get hold of it again
- Can move an object from one hand to another
- Can sit without help
- Is able to crawl
- May be able to stand with help.

Social
- Afraid of strangers
- Prefers a few special people
- May cry if a stranger gets too close or looks directly at him or her
- Likes to play with adults
- Primary caregiver is the most important person to him or her.

Intellect
- Likes to play games like peek-a-boo and hide-'n'-seek.

Language
- Learns to make many different sounds
- Uses sounds, changes of expression and moves around to get adults’ attention
- Begins to imitate sounds
4.4 Developmental milestones from nine months to one year

**Emotional**
- Shows affection
- Grows in confidence when adults allow him or her to try new things.

**Physical**
- Can pull self up and stand holding onto furniture.

**Social**
- Has fun making silly faces and noises with other children
- Struggles to share, but learns through supervised play with others.

**Intellectual**
- May use a stick or another object to reach a toy.

**Language**
- Knows own name
- Points to an object they want
- Learns to look at the ball when the adult says ‘ball’ in the child’s home language
- Is able to sense whether the adult is happy or upset from the tone of their voice and how much tension is in the adult’s body when they hold him or her.

4.5 Developmental milestones from 13 months to 18 months

**Emotional**
- Respects him- or herself when there is a sense that the adult is really listening
- Feels proud of what he or she can do and praise makes him or her feel even better
- Sometimes insists on doing things in his or her own way
- Laughs and may shriek with joy when happy and having fun
- May sometimes hit, push or bite because of anger or frustration
- Feels competent when the adult invites him or her to help
- Can be angry or frustrated and show it by saying ‘No!’ or ‘Mine!’
Physical
- Can make marks on paper with crayons
- Can stack and line up big blocks
- Can feed self with fingers and later on with a spoon
- Is able to drink from a cup
- Can sit in a chair
- Learns to walk, first with help and then alone
- Learns to walk forward, take a few steps backwards and try to climb stairs
- May begin to dress and undress themselves
- Is able to push their foot into a shoe and their arm into a sleeve.

Social
- Has favourite toys and favourite foods
- Adults can help peaceful play by providing duplicates of favourite toys
- Learns how to relate to other people by watching adults
- Likes to choose what to wear
- May role play simple scenes with others such as caring for dolls and talking on a cellphone
- Imitates adults’ actions like pushing a vacuum cleaner, sweeping and wiping
- Enjoys being given ‘adult’ tasks to do.

Intellectual
- Is able to solve problems such as going around a chair when chasing a ball, knowing that it will come out on the other side
- Enjoys wind-up toys, e.g. music box
- Is very interested in how the world works.

Language
- Can point to and tell the names of one or more body parts
- Points to pictures of interesting objects, animals and people in books
- May hit, kick or bite when frustrated or angry
- Creates long babbled sentences
- Uses sounds other than crying to get help
- May be able to say numbers two to ten (or more) clearly
- Listens to and watches adults because they understand more than just words
- Begins to use ‘I’, ‘me’ and ‘mine’
- Needs help to express feelings in an acceptable way.

4.6 Developmental milestones from 18 months to three years

Emotional
- Relies on adult to set clear and consistent limits that will keep him or her safe
- When testing the limits, is learning his or her place in the family unit and how to behave
- Has a sense of belonging when spoken to in his or her home language
- Feels proud when seeing pictures of him- or herself with other friends or family members hanging on the wall
• Feels safe when familiar adults work together to offer care
• Demonstrates self-respect when adults show him or her respect
• Knows when adults feel he or she is good or bad, pretty or ugly, smart or dumb
• Tunes in carefully to adult’s tone and words when they talk about him or her (Note: Please don’t talk about them as if they can’t understand)
• Sometimes wants to walk, other times wants a ride in the pram
• Sometimes insists on doing things his or her own way, other times wants an adult to do things for him or her
• Learns to control behaviour best when given only a few simple, clear rules to follow and an adult is there to remind him or her
• Feels proud of things he or she makes or achieves
• Can get very frustrated and angry and may hit, push or bite to express feelings
• May be afraid of the dark, imagined or illustrated monsters, and people in masks or costumes.

Physical
• Turns the pages of a book
• Scribbles with a crayon or marker and may be able to draw shapes, like circles
• Pounds and squeezes clay and makes shapes with a cookie cutter
• Can thread beads with large holes
• Is learning to use scissors
• Can kick and throw a ball
• Stands on one foot
• Is learning to stand and walk on tiptoe
• May be able to walk upstairs putting one foot on each step
• Is learning to eat with a spoon and fork, though sometimes uses fingers
• Can dress self in simple clothes
• Can pour milk on cereal.

Social
• Is aware of other children of the same age and sex
• Is aware of skin colour and may begin to be aware of physical differences
• Can tell who is missing from the group
• Is learning to use words to express feelings
• May pretend to go to work or cook supper
• Explores environment, going over couches or under tables
• Builds block towers
• Sometimes practises how to express feelings when playing
• Learns how to treat others by watching how adults treat others
• Shows care by imitating adults
• Is learning he or she doesn’t always get his or her own way
• Sometimes can control self when things don’t go his or her way, and sometimes can’t
• Is learning to take turns
• Sometimes shares.

Intellectual
• May be able to put toys in groups, e.g. putting all of the toys with wheels together
• Can find a familiar toy in a bag, even when he or she can’t see it
• May know up to 200 words in his or her home language and sometimes in a second language, and can put them together in sentences
• Can talk about things that happened yesterday and about things that will happen tomorrow
• May get frustrated when having trouble expressing him- or herself so needs adults to listen patiently; it may help if adults put into words what the child is trying to say.

Language
• Enjoys stories that are about something the child knows
• May sometimes listen for a long time, other times may listen for just a little while before losing interest
• Likes to join in when a story is told
• Sometimes likes to ‘read’ or tell a story
• Likes songs, finger plays and games with nonsense words
• Talks together with friends as they role play scenes about serving lunch, driving a car or cleaning a house
• Sometimes improvises by using an object as something else, e.g. a block becomes a telephone.

4.7 Developmental milestones from three to four years

Emotional and social
• Develops friendships
• Plays with other children, instead of just side by side
• Follows simple directions
• Enjoys helping with household tasks
• Begins to recognise own limits, asks for help
• Does not cooperate or share well
• Is able to make choices between two things
• Begins to notice other people’s moods and feelings.

Physical
• Walks along a straight line and runs around obstacles
• Balances on one foot for five to ten seconds and is able to hop on one foot
• Pushes, pulls and steers wheeled toys and rides a tricycle
• Uses a slide independently
• Jumps over 10 cm high objects and lands on both feet together
• Throws ball overhead and is able to catch a bouncing ball
• Builds tower of nine small blocks
• Drives nails and pegs
• Able to copy a drawing of circles or a cross
• Manipulates clay material (e.g. rolls balls, snakes, cookies).

Intellectual
• Can describe how two objects are used
• Uses four to five words in a sentence
• Names two actions (e.g. skipping, jumping)
• Can follow a two- or three-component command
• Gets dressed without help
• Understands most of what is said
• Matches pictures to objects
• Learns by doing and through the senses
• Understands concepts of ‘now’, ‘soon’ and ‘later’
• Recognises cause-and-effect relationships.

**Language**

• Hears when being called from another room
• Hears television or radio at the same loudness level as other family members
• Understands simple Who, What, Where and Why questions
• Talks about activities at school
• Uses a lot of sentences that have four or more words
• Usually talks easily, without repeating syllables or words
• Uses the pronouns ‘I’, ‘you’ and ‘me’ correctly
• Uses some plurals and past tenses
• Knows at least three prepositions, usually ‘in’, ‘on’ and ‘under’
• Has a vocabulary of about 900-1000 words
• About 90% of what is said should be intelligible
• Verbs begin to predominate
• Knows chief parts of the body and should be able to indicate these, if not name them
• Understands most simple questions dealing with the immediate environment and activities
• Relates experiences in a logical way
• Is able to reason out such questions as, “What must you do when you are sleepy, hungry, cold or thirsty?”
• Should know own sex, name and age.

### 4.8 Developmental milestones from four to five years

**Emotional and social**

• Takes turns, shares and cooperates
• Expresses anger verbally rather than physically
• Can feel jealousy
• May sometimes lie to protect him- or herself; understands the concept of lying
• Enjoys pretending and has a vivid imagination.

**Physical**

• Walks backward toe-heel
• Jumps forward ten times without falling
• Walks up and down stairs independently, alternating feet
• Turns somersaults
• Cuts on a line continuously
• Copies a drawing of a cross
• Copies a drawing of a square
• Prints some capital letters.
Intellectual
- Uses a 1 500 word vocabulary
- Uses relatively complex sentences
- Understands the difference between fantasy and reality
- Understands number and space concepts ‘more’, ‘less’ and ‘bigger’
- Still thinks literally
- Beginning to grasp that pictures and symbols can represent real objects
- Recognises patterns among objects
- Grasps the concept of past, present and future but still doesn’t understand duration of time.

Language
- Pays attention to a short story and answers simple questions about it
- Hears and understands most of what is said at home and at school
- Voice sounds clear like other children’s
- Uses sentences that give detail (e.g. “I like to read my books”)
- Tells stories that stick to a topic
- Communicates easily with other children and adults
- Says most sounds correctly
- Uses the same grammar as the rest of the family
- Knows names of familiar animals
- Can use at least four prepositions or can demonstrate his or her understanding of their meanings when given commands
- Names common objects in picture books or magazines
- Knows one or more colours
- Can repeat four digits when they are given slowly
- Can usually repeat words of four syllables
- Demonstrates understanding of ‘over’ and ‘under’
- Often indulges in make-believe
- Extensive verbalisation as he or she carries out activities
- Understands such concepts as ‘longer’ and ‘larger’ when a contrast is presented
- Readily follows simple commands even though the stimulus objects are not in sight
- Much repetition of words, phrases, syllables and sounds.

4.9 The neurological impact of HIV and AIDS on children

When HIV is passed from mother to child, the virus has an impact at an early stage when there is no immune system in effect. HIV has been found in the brain as early as two days after initial infection (Bowers). Half of all children living with HIV and AIDS are affected by cognitive problems. This is because HIV can enter the brain and infect parts that are vital for learning and living. The child’s cognitive development is then impaired in all areas – academic, physical and social. Premature birth, low birth weight and mental problems are some of the problems a child will face, and these escalate over time.

Children living with HIV and AIDS are also subject to a depressive disorder during the illness. In addition to having cognitive disabilities leading to a failure in understanding simple things, they suffer depression. These children may not understand why they are depressed, resulting in more anguish.
Treatment made available to the children should slow down the infections and eventually prevent the infections from occurring.

**Neuropsychological problems in children living with HIV and AIDS**

**Developmental delays in infancy**
- Declines in intellectual/cognitive functioning
- Language delays
- Gross and fine motor deficits
- Attention Deficit Disorder
- Hyperactivity
- Emotional disorder (withdrawal, depression, apathy)
- Progressive cognitive impairment may be due to Central Nervous System (CNS) effects of HIV
- Loss of paediatric milestones already passed
- Short-term memory loss
- Acquired microcephaly (abnormally small brain)
- Cerebral atrophy (brain tissue wasting), calcifications (calcium deposits) in basal ganglia (nerve structures deep inside the brain) and white matter changes.

**4.10 Activity – Understanding basic developmental milestones**

It is important to recognise the potential of each child as a unique individual. Interaction with a child in a nurturing environment provides the foundation for developing the child’s full potential. Being aware of the child’s developmental abilities and the factors affecting his or her development, will allow for maximum developmental interventions.

*Aim:* Develop an understanding of basic developmental milestones

Select and insert the appropriate age by which a child should have mastered the milestones in the table below.

<table>
<thead>
<tr>
<th>Birth – 3 months</th>
<th>3 – 6 months</th>
<th>6 – 9 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 – 12 months</td>
<td>13 – 15 months</td>
<td>18 months – 3 years</td>
</tr>
<tr>
<td>3 – 4 years</td>
<td>4 – 5 years</td>
<td>5 – 6 years</td>
</tr>
</tbody>
</table>
### Developmental milestones table

<table>
<thead>
<tr>
<th></th>
<th>Appropriate age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Learns to walk on their own</td>
</tr>
<tr>
<td>2</td>
<td>Can stand on one foot</td>
</tr>
<tr>
<td>3</td>
<td>Discovers that hand and feet are a part of their body</td>
</tr>
<tr>
<td>4</td>
<td>Prints some letters</td>
</tr>
<tr>
<td>5</td>
<td>Sucks on fingers</td>
</tr>
<tr>
<td>6</td>
<td>Walks up and down stairs alternating feet</td>
</tr>
<tr>
<td>7</td>
<td>May be able to stand if supported</td>
</tr>
<tr>
<td>8</td>
<td>Runs around obstacles</td>
</tr>
<tr>
<td>9</td>
<td>Can move object from one hand to the other</td>
</tr>
</tbody>
</table>

### 4.11 Activity – The impact of HIV and AIDS on a child’s development

**Aim:** To reflect on the neurological impact of HIV and AIDS on a child’s development

1 **Fatigue**

2 **Fits**
3 Muscle degeneration

4 Eye impairments

4.12 Activity – Accommodating neurological delays

Aim: Discuss ways in which resources can be altered to accommodate neurological delays

Notes
Module 5: Stimulation and development programmes

Aim of this module

Module 5 aims to address the developmental needs of children living with HIV and AIDS.

Learning outcomes

By the end of this module, the trainee should be able to:

✓ Demonstrate an understanding of the concept ‘stimulation’
✓ Understand the need to stimulate children living with HIV and AIDS
✓ Identify and explain what aspects of developmental growth should be stimulated.

Further reading

✓ Daily sensorimotor by William T. Braley; Geraldine Konick; Catherine Leedy (suitable for 3–5 year olds)
✓ Just for Babies by Theodosia Sideropoulos Spewock
5.1 Introduction

Children should be able to reach and accomplish certain milestones (development challenges, such as walking, talking and socialising) as they develop. Babies and children living with HIV and AIDS generally do not develop and progress at the same rate as children who are not infected. At times, they do not progress at all. The first four to five years of a child’s life are very important since 50% of the child’s intellectual development takes place between birth and five years.

Children living with HIV and AIDS must be stimulated and allowed to play. They must not be made to feel different from other children. Even though children living with HIV and AIDS develop more slowly than non-infected children, they must be given the opportunity and be encouraged to learn. Accomplishing milestones and being acknowledged for this, will encourage the development of a happy and mentally healthy child.

5.2 What is stimulation?

Stimulation can be defined as provoking interest or increasing alertness of the mind and body in activity through play; also to goad, or prod and incite one into action and stir up what is latent. It is important to stimulate the intellectual, social, emotional, spiritual and physical development of children living with HIV and AIDS. Through play, children learn problem solving, interpersonal skills, communication and other skills integral to success in school and life. Playing with your child is not only fun – it is one of the most important ways to nurture development. There are no rules when it comes to play. Play is truly the work of childhood!

5.3 Importance of stimulation

Effective learning can only take place in a relaxed, nurturing atmosphere. There must be a warm, loving relationship between the care worker, the teacher and the child, based on mutual acceptance and respect. This will nurture a positive self-image and the child will begin to feel good about him- or herself.

- When children living with HIV and AIDS play, they learn
- They use their senses
- They begin to understand how their bodies move and function
- When they explore, they discover new things
- They start to use language to express their needs and desires.
5.4 Aspects of stimulation

Decades of research clearly demonstrate that play which is active and full of imagination, is more than just fun and games. It boosts the healthy development of children living with HIV and AIDS across a broad spectrum of critical areas: intellectual, social, emotional, spiritual and physical. The benefits are so impressive that every day of childhood should be a day for play.

To understand the normal development of a child living with HIV and AIDS, one must be aware that there are different aspects of development. Concentrating on only one aspect may benefit the child, but it will not lead to an understanding of the child holistically. Children living with HIV and AIDS need daily stimulation in all aspects of development.

Cognitive/intellectual development

Intellectual development refers to our ability to think, understand and reason.

The child is born with the normal capacity for intelligence, the brain. However, these building blocks of intelligence only begin to develop when the child moves, explores, manipulates, sees, describes and makes use of the elements of his or her world.

A baby’s intelligence is influenced by:

- Biological intelligence: the genetic intelligence inherited from his or her parents.
- Cultural intelligence: influenced by the child’s culture and the stimulation received from that culture.
- Environmental intelligence: influenced by the different environments the child is exposed to and the stimulation received from these environments.

Language development

Language is unique to man and is the highest human achievement. The child must learn to develop competence in language and speech.

The three main purposes of language are:

- To communicate (feelings, information and thoughts)
- To develop our thought processes (learn, remember and understand)
- To assist in the transmission of culture (learn and gain knowledge from past generations)

Emotional expression

Every human experiences many emotions. These include love, happiness, contentment, excitement, worry, fear, sorrow, anger, pride, jealousy and frustration. The intensity of these emotions will depend on your child’s personality and his or her age. Babies have a powerful inborn ability to communicate their emotional needs which they express through their behaviour. In the early stages, their greatest emotional need is for affection.

Emotional development will be influenced by their inborn temperament and environment. A child may be a natural extrovert with a happy personality or may be shy and introverted. Early experiences in the home and the type of emotional input they receive from parents and caregivers will have a direct influence on how they deal with their emotions and express themselves. This in turn affects the way in which they share their feelings and deal with worry and frustration.

Motor/muscle development

Movement is a fundamental need for every child living with HIV and AIDS, on the same level of importance as healthy eating and sleeping. A child is born with an inner drive for movement and most children discover this drive spontaneously and use it to move.
The child plays movement games which involve the whole body, physically and mentally. These movement games give the child’s muscles exercise and at the same time develop many critical physical and perceptual skills needed for learning.

5.5 Ideas on how to stimulate a child with HIV and AIDS

There are endless activities ideal for stimulating an HIV and AIDS child.

**Gross motor coordination**
Gross motor activities are those which help stimulate and develop the large muscles of the body. Activities which use the body’s large muscles can be incorporated into most physical games. Look around your environment and use existing apparatus in these activities and games, e.g. tables, chairs and low bricked walls. Gross motor activities are also useful in identifying a child’s dominate side (left or right).

**Games that require physical exertion**
- Leap frog.
- Hop scotch.
- Following obstacle courses.
- Jumping games with ropes and elastics.
- Pushing and pulling objects that are different sizes and weights, e.g. a wagon filled with Lego® blocks in comparison to a wagon filled with mud.
- Playing games to reinforce the following spatial awareness concepts: under and over, left and right, up and down, in front of, in the middle, next to and behind.

**Large movement activities**
- Kicking and punching into the air or against a hanging punching bag.
- Climbing onto, up and down apparatus (garden jungle gyms).
- Running races and games including running while balancing a large stone on a tablespoon, three-legged races and relay-team races.
- Rolling on a carpeted floor or grass patch, either sideways or head first.

**Ball skills**
Most of the skills practice done with balls can be done with beanbags as well.

**Throwing balls:**
- Throwing balls of different sizes, shapes and weights.
- The younger child can be encouraged to roll or push a ball away from their body.
- Throwing balls includes throwing overhead, underhand, throwing with both hands (use bigger balls) and throwing with only one hand.
- Throwing balls into buckets or boxes. The distance between the child and the bucket or box can gradually be increased as the child becomes more accurate and older.
**Kicking balls:**
- Kicking balls of different sizes, shapes and weights.
- Kicking balls using both the front of the foot (i.e. toes) and the sides of the foot.
- Kicking a stationary ball. Once the child has become accurate in kicking the ball this way, they can then start kicking a ball in motion. You can either roll or gently kick a ball in the child’s direction. You can also allow the child to stop a moving ball using their feet before they kick the ball away from themselves.
- Children who are able to, should be allowed to run whilst kicking the ball (soccer-type games).

**Fine motor coordination**
Fine motor refers to the use of the small muscles in the body. Development of these muscles is necessary in order to master the skills required to complete any small movement activities. These activities include cutting and writing skills, as well as tasks such as manipulating a knife and fork, or doing up the buttons on a jersey.

**When children are busy doing fine motor activities, it is important to check the following:**
- The child should be sitting with their body placed directly in front of the activity. Make sure they are not at an awkward angle as this will limit their concentration, as well as form a barrier to what they should be doing.
- The child should be seated at a table and chair which is of the correct size. Their feet should be placed together and resting on the floor. The table should not be too low, as this will mean the child will have to bend down to work. The child’s forearms should rest comfortably on the table-top.
- The child must be encouraged to support their work with their non-dominant hand.
- Encourage a 3-point finger grip when holding writing or colouring instruments.

**Cutting**
Cutting activities will vary according to age as well as existing fine motor development. Ensure that prior to the cutting activity, the child has been pre-assessed and you have the most suitable cutting tools available for the child as well as the activity.

**Assess children’s cutting with questions such as:**

1. Which hand does the child use?  
   (Left- or right-handed scissors.)

2. Can the child independently open and close the pair of scissors?  
   (Does the child have sufficient strength in their hand? Test the pair of scissors and check their tension.)

3. Does the child need assistance to hold the pair of scissors?  
   (Use dual-control scissors.)

**When cutting lines and shapes, encourage the child to:**
- Point the tip of the scissors to follow the line they will be cutting. The child is to look at the point of the scissors. If the child struggles to watch the tip, draw attention to the tip by painting it with a bright colour.
- Demonstrate to the child the correct way the scissors should be lined up against the cutting line.
- The child is to hold the paper with their non-dominant hand. They should hold the paper close to the scissors as this will prevent the paper from tearing.
- Encourage the child not to pull the paper through the scissors.
The older child can cut away the excess paper around a particular shape to make manoeuvrering the paper easier.

Tearing paper
- The very young child can be encouraged to rip paper; this can then be developed into controlled tearing of paper.
- The young child must be encouraged to tear long strips of paper and then smaller bits, which can be collected and used in a collage.

Cutting with scissors
Snipping:
- Allow the child to hold the scissors and snip the edge of a piece of paper. This activity allows the child to adjust to holding a pair of scissors and practising the cutting movement.

Fringing:
- The adult can draw a horizontal line across the bottom of the page.
- Draw vertical lines from the horizontal line to the bottom of the page. The vertical lines should be about 2 cm apart.
- The child can then cut the vertical lines, stopping at the horizontal line.
- This activity can be extended to include the child cutting a strip of paper.

Shaped and curved lines:
Remember to give children activities which are age appropriate to their development. Activities which are either too easy or too difficult will frustrate the child and possibly hinder their learning.
- It is important to encourage the child to use their non-dominant hand to manoeuvre the paper into the correct directions for the shape.
- The dominant hand is used to manoeuvre the scissors only.

Auditory discrimination
Auditory discrimination refers to the development of the child’s listening skills. Activities can vary according to age and environment.
- Make children aware of the sounds in their environment. Encourage them to identify and mimic sounds in the home, e.g. a telephone ringing, running water, a teaspoon tapping against a tea mug, etc., and sounds outside the home, e.g. an aeroplane flying above, motor cycles driving by, birds chirping in the trees, etc.
- Listen to music with the child. Point out the different sounds that different musical instruments make.
- Sing songs with the child. Sing songs which require different tones, pitches and speeds of their voice, e.g. sing slowly but loudly.
- For the older child, allow them to name objects in a picture book. Help the child to identify how many syllables are in each word. Clap these syllables with the child, e.g. a / pple, ta / ble and a / ni / mal.

Visual discrimination
Visual discrimination is the ability to identify the differences in objects, colours, shapes, etc. using the functions of the eyes only.
- Assist children in learning and identifying different colours and shapes.
- Colour and shape recognition can be linked to objects in and around the child’s environment, e.g. the plate is a circle, the grass is green, etc.
Encourage the child to look at both 1D, 2D and 3D pictures and objects. This will include being able to identify which objects are in the front and which objects are in the background.

**Language**

Language development refers to the development of the way the child speaks and is able to understand spoken language.

- Do not use ‘baby talk’ when speaking to children.
- Use everyday situations to teach new vocabulary.
- The more experiences a child has, the more words he will hear and pick up in his vocabulary.
- Develop the child’s concept of collective nouns, e.g. a chair, a table and a couch are all types of furniture. There are many categories: fruits, vegetables, animals, transport, etc. It is helpful to make posters of collective nouns and to hang these on the wall to be referred to repeatedly.
- Speak to a child about their current themes at school. Ask open-ended questions that will form a discussion about the themes. This will also assist in the development of the child’s memory.
- Use descriptive language; encourage the child to name and describe objects.
- Read stories to the child. Alternate reading stories that do and do not have pictures. Let the child visualise the story and then retell it to you.

**Emotional and social (life skills)**

Emotional and social development refers to the development of the children’s independence, self-confidence and responsibilities.

- Allow children to dress and undress themselves.
- Teach children to put on their own shoes and tie their laces.
- Let children make their own beds.
- Encourage children to do chores around the house to develop a sense of responsibility.
- Older pre-schoolers are expected to look after their clothing and belongings at school, including their stationery and lunch boxes.
- Develop children’s self-confidence by encouraging them to pray (if you are aware of their religious status) and to sing and say rhymes by themselves.
5.6 Activity – Stimulation activities

**Aim:** To provide examples of stimulation activities

1. A two-year-old child who is struggling with large muscle activities:

2. A baby who has poor grip:

3. A four-year-old child who has poor language skills:
5.7 Activity – Stimulation programmes

**Aim:** To develop stimulation programmes

### Stimulation programme from birth to 12 months (example)

<table>
<thead>
<tr>
<th>Skill</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language and social development</td>
<td>Carried out throughout the day.</td>
<td>Music to be played daily.</td>
<td>Talking to babies during all activities.</td>
<td>Feeding babies and maintaining good eye-to-eye contact.</td>
<td>Talking to babies while feeding.</td>
</tr>
<tr>
<td>Cognitive (intellectual and mental) development</td>
<td>Items of daily use: Manipulation. Reaching out for objects.</td>
<td>Use of sound-producing toys like rattles, bells, drums, etc.</td>
<td>Manipulation of objects that are different shapes and sizes.</td>
<td>Paper play: Crushing of paper. Use of things made out of paper.</td>
<td>Exposure to outside environment: plants flowers birds animals.</td>
</tr>
</tbody>
</table>

### Indoor and outdoor stimulation programme for 1 – 2½ years (example)

<table>
<thead>
<tr>
<th>Skill</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language and social development</td>
<td>Carried throughout the day.</td>
<td>Children to be spoken to constantly. Brief and clear instructions for all activities.</td>
<td>Identification of different pictures and objects. Repetition as frequently as possible.</td>
<td>Music to be played daily. Singing songs, rhymes, lullabies.</td>
<td>Talk constantly to children. Always involve them in conversations.</td>
</tr>
<tr>
<td>Skill</td>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
<td>Friday</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Motor development (gross and fine)</td>
<td>• Helping children to stand and walk without support.</td>
<td>• Running. • Jumping.</td>
<td>• Climbing stairs. • Activities on swings, slides, see-saws.</td>
<td>• Use of pull-along toys.</td>
<td>• Free play.</td>
</tr>
</tbody>
</table>

Develop and complete a stimulation programme on the provided template. It is important to develop the stimulation programme with a specific age group in mind.

Look around and try to utilise equipment or apparatus that already exists, e.g. chairs.

**Stimulation programme template**

<table>
<thead>
<tr>
<th>Skill</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language and social development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive (intellectual and mental)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor development (gross and fine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

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Module 6: Record-keeping assessments

Aim of this module
Module 6 aims to provide an understanding of the child’s circumstances and needs.

Learning outcomes
By the end of this module, the trainee should be able to:
✓ List information which is necessary to record
✓ Complete a general observation record.
6.1 Introduction

Accurate and up-to-date record keeping is important to compile a history of each child from admission to discharge. It allows the institution to identify and monitor any patterns in behaviour, as well any areas of concern and/or significant changes.

Should it become necessary to refer the child for additional assistance, the person or organisation to which the child is referred will require detailed information on the child.

6.2 Activity – Implications of an observation record

Aim: Discuss the practical implications of an observation record

Notes

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6.3 Activity – Admission forms

Aim: Design an admission form
<table>
<thead>
<tr>
<th>Observation record (example)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Surname:</td>
</tr>
<tr>
<td>Date of birth:</td>
</tr>
<tr>
<td>Weight:</td>
</tr>
<tr>
<td>General development:</td>
</tr>
<tr>
<td>Milestones achieved:</td>
</tr>
<tr>
<td>Milestones not achieved:</td>
</tr>
<tr>
<td>Strengths:</td>
</tr>
<tr>
<td>Recommendations:</td>
</tr>
<tr>
<td>Social development:</td>
</tr>
<tr>
<td>Current friends:</td>
</tr>
<tr>
<td>General behaviour:</td>
</tr>
<tr>
<td>Problematic behaviour:</td>
</tr>
<tr>
<td>General health:</td>
</tr>
<tr>
<td>Goals:</td>
</tr>
<tr>
<td>Actions to be taken:</td>
</tr>
<tr>
<td>Referrals:</td>
</tr>
<tr>
<td>Staff member's details:</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Surname:</td>
</tr>
<tr>
<td>Staff number:</td>
</tr>
<tr>
<td>Signed by:</td>
</tr>
</tbody>
</table>
6.4 Assessment record-keeping

It is important to document a variety of information relating to each child in order to track his or her history and progress from the time of admission. This information includes:

✓ Admission form
  - General details, e.g. name, date of birth
  - Physical assessment, e.g. weight, height, scars
  - Immunisations
  - Palliative care
  - History – presenting problem
  - Physical assessment

✓ Medication administration schedule
  - Date
  - Time
  - Dose

✓ Prescription chart
  - Acute – drug, frequency, duration
  - Chronic – prescribing doctor, change in dosage

✓ Assessment form
  - Date
  - Child’s details
  - Admission details
  - Birth history
  - Family history
  - Milestones
  - Medical history
  - Clinical examination
  - Special investigations
  - Referrals
  - Prescribed medication
  - Follow-up
  - Recommendations/comments

✓ Feeding chart
✓ Weight chart
✓ Growth chart
**Example of progress report**

(Insert logo)

**Progress report**

3 – 6 months old

<table>
<thead>
<tr>
<th>Name and surname:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
</tr>
<tr>
<td>Height:</td>
<td></td>
</tr>
<tr>
<td>Weight:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language development</th>
<th>Highly competent</th>
<th>Competent</th>
<th>Needs assistance</th>
<th>Not yet competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smiles at the sound of your voice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Babbles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imitates some sounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turns head towards direction of sound</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turns head towards bright colours and lights</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turns towards the sound of a human voice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognises bottle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responds to rattle or bell shaking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**By six months**

| Babbles, making almost ‘sing-song’ sounds |       |       |                  |                   |
| Recognises familiar faces |       |       |                  |                   |
| Laughs and squeals with delight |       |       |                  |                   |
| Screams if annoyed |       |       |                  |                   |
| Smiles at him- or herself in a mirror |       |       |                  |                   |

**General:**
### Social development

<table>
<thead>
<tr>
<th>Highly competent</th>
<th>Competent</th>
<th>Needs assistance</th>
<th>Not yet competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develops a social smile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoys playing with other people, and may cry when playing ends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More communicative and expressive with face and body</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imitates some movements and facial expressions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smiles when smiled at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicates hunger, fear, discomfort (through crying or facial expression)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usually quietens down at the sound of a soothing voice or when held</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipates being lifted by reaching out with his or her arms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reacts to ‘peek-a-boo’ games</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognises own name</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**By six months**

<table>
<thead>
<tr>
<th>Highly competent</th>
<th>Competent</th>
<th>Needs assistance</th>
<th>Not yet competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blows bubbles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imitates sounds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General:**
<table>
<thead>
<tr>
<th>Motor skills</th>
<th>Highly competent</th>
<th>Competent</th>
<th>Needs assistance</th>
<th>Not yet competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raises head and chest when lying on stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports upper body with arms when lying on stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stretches legs out and kicks when lying on stomach or back</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opens and shuts hands</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pushes down on legs when feet are placed on a firm surface</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brings hand to mouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaches out for dangling objects with hands</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grasps and shakes hand toys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watches faces intently</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows moving objects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognises familiar objects and people at a distance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starts using hands and eyes in coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifts head when held at caregiver’s shoulder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifts head and chest when lying on his or her stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turns head from side to side when lying on stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grasps rattle when given</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has started cutting teeth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>By six months:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holds head steady when sitting with support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaches for and grasps objects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plays with his toes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helps hold the bottle during feeding</td>
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<td>Explores by mouthing and banging objects</td>
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<tr>
<td>Moves toys from one hand to another</td>
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<td>Shakes a rattle</td>
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<tr>
<td>Motor skills</td>
<td>Highly competent</td>
<td>Competent</td>
<td>Needs assistance</td>
<td>Not yet competent</td>
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<td>Pulls up to a sitting position on own if caregiver grasps hands</td>
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<td>Sits with only a little support</td>
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<td>Sits in a high chair</td>
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<td>Rolls over in both directions</td>
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<td>Bounces when held in a standing position</td>
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<td>Opens mouth for spoon</td>
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<td>Imitates familiar actions caregivers perform</td>
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<td>Eats solids</td>
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<td>Starts crawling</td>
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**General:**

**Observations and general feedback:**

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**Checked by:** ............................................

**Moderated by:** .........................................

**Date:** ..................................................
Module 7: Psychosocial impact of HIV and AIDS on young children

Aim of this module

Module 7 aims to provide an understanding of the psychosocial impact of HIV and AIDS on young children.

Learning outcomes

By the end of this module, the trainee should be able to:
✓ Identify the psychosocial impact of HIV and AIDS on young children.
7.1 Case study

This is a story about a family that has been severely impacted by HIV and AIDS. The family comprised a mother, father and three children – a girl called Zodwa who was four when we first met and twin boys, Themba and Sipho, who were two years old. The father died from an AIDS-related illness a year ago, leaving the mother to care for her three young children alone. The mother did not tell her own family, who lived in the Eastern Cape, that she and the twins were HIV positive, nor the cause of her husband’s death, so she received no support from them. Shortly after the father died, the mother’s health also began to deteriorate. This was probably as a result of the loss of the family breadwinner, the grief of losing her husband and the stress of adapting to life without her spouse. More and more responsibility for caring for the family fell on Zodwa, even though she was still very young. It became her duty to care for her younger brothers and to find food for the family. The twins began seeing her as the mother figure in their lives.

These changed circumstances had the following impact on the family:

- The children started showing signs of malnourishment.
- Their hygiene suffered and this, together with poor diet, increased their vulnerability to opportunistic infections.
- Poor living conditions contributed to the family’s health problems. They lived in a shack in an informal settlement that had no running water, no bathroom facilities and no electricity. The communal toilet was far from the house and when the mother was too ill to accompany her, Zodwa had to walk on her own to use the toilet. This increased her vulnerability to abuse.
- Although the twins started on ART, the family circumstances meant that they did not comply with the regime, so treatment was stopped.
- The mother was afraid to ask for help from the neighbours as she did not want to disclose her family’s HIV status, so she started to avoid them.
- The mother and children stopped attending the HIV clinic for fear that someone would find out that they were living with HIV and AIDS.
- All three children lost their trust in adults, perceiving that they had been let down by their parents, firstly by their father dying, followed by their mother’s inability to care for them. They were too young to understand the reasons for this.
- At the age of two, neither twin could sit or crawl, their verbal skills were undeveloped and they displayed signs of serious developmental delays.
- Zodwa could not attend pre-school as she had to care for her family and there was no money available to pay the fees anyway.

The circumstances at home deteriorated to the point that the neighbours, who really were concerned for the children, reported the family to the authorities. Unfortunately, by the time this happened, the situation at home was so serious that the children had to be removed as the mother no longer had the emotional, physical or financial resources to provide for them. She was admitted to hospital and later transferred to a TB facility, and the children were placed in the care of Cotlands.

On admission to Cotlands, the following behaviour was noted:

**Zodwa (four years old)**

- She displayed signs of being a parentified child and had a lot of difficulty relinquishing responsibility for her brothers to the caregivers.
- She couldn’t relate to children her own age and did not know how to play or behave like a child.
She lacked trust in adults as her emotional needs had not been met.
She displayed signs of anger and depression.
Although she didn’t eat compulsively, she tended to hide food away for later.
In the classroom setting, she struggled to adapt to the routine, interact with her peers and teacher, follow the developmental programme and had no knowledge of how to function in an educare system. She was often overwhelmed in this setting.
She was very tearful and even when she wasn’t crying, she always seemed close to tears.
She constantly asked to see her mother.

Themba and Sipho (two years old)
They showed marked delays in their physical and mental development and were way behind in their developmental milestones, functioning at below a six-month level.
They were reliant on their sister and emotionally dependent on each other for comfort and could not settle down unless they were all together.
They ate excessively and never seemed satisfied.
They were anxious about the activity, noise and equipment in their new environment, which made them fretful.
When they were made to sit (with support) they cried continuously, most likely because this position was painful and unfamiliar.
They responded in the same manner towards adults and children and did not clearly differentiate between the different age groups.
Apart from crying, they made no attempt to communicate.

Six months later, in an environment in which all their physical needs are being met and their emotional, psychological, developmental and medical needs are being addressed, the following is noted:

Zodwa (five years old)
Zodwa struggles to develop relationships, as she still does not trust adults. She hasn’t bonded with any staff members or volunteers, despite continual efforts.
She still seeks solace in her brothers and continues to feel responsible for them. As she is not in the same unit, she frequently feels the need to go in and check on them.
She remains tearful.
She does not have the emotional resources to deal with her feelings and acts out these feelings by behaving in a destructive and aggressive manner.
She often withdraws from a group setting, although she is making some effort to join in activities with her peers.
She is making some progress with play and is starting to explore, using the play equipment available to her.
Contact with her mother is extremely traumatic for her. She becomes very anxious before each visit, heightened by the fact that her mother is still seriously ill and as a result of AIDS-related dementia, doesn’t always recognise her children.
Zodwa never asks to see her mother and all contact with her must be initiated by Cotlands.
Grief is displayed as despair and helplessness.
She still feels abandoned by her parents and is angry with them.
She is anxious about learning and fears failure.
Themba and Sipho (two years old)
- They have adapted far more readily to their new environment.
- They have formed attachments with staff and volunteers.
- They are more comfortable with touch and will actively seek out an adult to be held and cuddled.
- They feel safe enough to explore their surroundings.
- They show excitement about their physical progress and have made tremendous progress, although they are still significantly delayed.
- They are still closely bonded to their sister.
- They still continue to eat excessively and never seem satisfied.
- They do not recognise their mother as an important figure in their lives and will cling to the caregiver when visiting her.
- They are playful, laugh a lot and appear relaxed and content.
- They seem to have overcome the early trauma in their lives.

7.2 Activity – Understanding the impact of HIV on a family

**Aim:** To illustrate the impact HIV has on a family
Module 8: Family and community support systems

Aim of this module
Module 8 aims to equip the trainee with basic information on the role and importance of family and community support systems.

Learning outcomes
By the end of this module, the trainee should be able to:
✓ Assist families in evaluating choices and options
✓ Demonstrate the knowledge of available community resources and services.

Further reading
✓ HIV and AIDS Care and Counselling: Alta Van Dyk
✓ Community Help for Children Living in an HIV+ World: Noreen Ramsden
8.1 The circles of help

Families and the community have an indispensable role to play in the care and support of children with HIV and in ensuring that they are not deprived of their basic rights to shelter, food, health and education. However, the burden of caring for these children falls on families who are already poor and need help from the community.

The circles of help start with neighbours and friends, and then widen to include those concerned with children.

They begin in the immediate community and spread beyond.

**First circle** – Neighbours and Friends

**Second circle** – Community Child Help Team

**Third circle** – The State

1. First circle – Neighbours and Friends
   - They may provide material help in the form of food and clothes.
   - They may provide physical help by caring for the child while the mother is running errands or needs to rest.
   - They may take the child for hospital appointments or collect the required medication.
Second circle – Community Child Help Team
- Community caregivers are people in the community trained to help the primary caregivers with direct care and support. Community caregivers may be professionals or volunteers.
- Professional caregivers such as nurses, community health or TB workers, medical doctors, psychologists or counsellors, pharmacists, physiotherapists and occupational therapists.
- Trained volunteers and others who offer supportive services such as residential care, respite services, pastoral care, legal aid and advice, transport services and the staff of various NGOs and CBOs (Community Based Organisations).
- Community support from community leaders, traditional leaders, village committees, religious and spiritual leaders, teachers and youth groups.

Third circle – The State
According to South Africa’s Constitution, the State has the responsibility of helping families and communities to meet the needs of children. The Department of Social Development provides four kinds of grants for children:
- The Child Support Grant is given to any person who takes care of a child under the age of 11. To apply for the grant, the total household income should be less than R800 (if you live in a town or city) and less than R1 100 if you live in a rural area or informal settlement.
- The Care Dependency Grant is given to parents or foster parents of children who need constant care. HIV-positive children qualify for this grant. Medical reports and the report of a social worker must be handed in with the application to the office of the Department of Social Development. The income of parents is assessed, but not that of foster parents.
- The Foster Care Grant is given to the caregiver of a child who is not their own. This process can only be facilitated by a social worker from a local Child Welfare Society.
- The Social Relief Grant is a temporary grant, given to caregivers who have applied for a permanent grant and are waiting for this application to be processed.

Families and communities can do so much together to help meet the needs of children.
8.2 Activity – Case study

Aim: To demonstrate the ability to identify relevant family and community resources

Thami was orphaned by HIV two years ago. He is 15 years old and lives with his grandmother and two of his four brothers, who are both on ART. His eldest brother (18) has gone to Durban to look for work. None of the children attends school and they survive on their grandmother’s pension. Thami has not seen his father for more than five years. The last he heard of his father was that he was employed at a petrol station in Pietermaritzburg as a cashier. The family does not get any support from their extended family members. Thami does not know what he will do if his grandmother dies and the family lose her pension. He is the second eldest in the family and will have to provide for their needs. There is no employment in the area.

- Who should be responsible for Thami and his siblings’ support: the father, grandmother, other family members, or the State? Motivate and suggest how such support can be obtained.
- If Thami were living in your area, where would you refer him for help?

Notes

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## 8.3 Community resources – template

### Community resources

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Module 9:
Communication with children living with HIV and AIDS

Aims of this module
Module 9 aims to reinforce the trainee’s prior knowledge and understanding of how to communicate effectively with children. It also provides an overview of how the psychosocial aspects of children are influenced by the development of their self-esteem and discipline.

Learning outcomes
By the end of this module, the trainee should be able to:
✓ Demonstrate the ability to communicate effectively with babies or young children living with HIV and AIDS
✓ Demonstrate knowledge of factors that affect the communication process with babies and young children living with HIV and AIDS.

Further reading
✓ Speech and language: Cause, milestones and suggestions by Kimberly A. Powel
✓ Positive Discipline by Jane Nelsen
✓ Bringing Up Kids Without Tearing Them Down by Dr. Kevin Lemon
9.1 Activity – Communication and psychosocial development

**Aim:** To demonstrate the ability to communicate effectively with children about HIV issues and to show knowledge of factors that affect the communication process

**Trainee’s instructions**
- This activity could be prepared the day before as homework.
- Ideas on different activities which could be done with children in order to encourage communication skills are:
  1. Stories (flannel board, books, puppets, dramatisation, etc.)
  2. Creative activities (movement, art activities, etc.)
    - Prepare an activity to do with the child which will encourage communication skills.
    - Before you present your activity, answer questions 1-3.

**Question 1:**
How will the age of the child affect the communication process?

*Answer:*

**Question 2:**
How will the child’s physical state of health affect the communication process?

*Answer:*
Question 3:
How will self-esteem and discipline affect the psychosocial aspect of the child?

Answer:

Activity (continued):

Trainee’s instructions continued:
- Prepare all material and equipment needed for the activity.
- Explain to the child and to the trainer what activity you are going to do.
- Present the activity.
- The trainer will use the observation sheet to observe your activity.
- Afterwards, the trainer will give you feedback on your activity.
- Share with the trainer any difficulties you experienced during the activity.

9.3 Additional information

Erikson’s Stages of Psychosocial Development
(Taken from Psychology 101 The virtual psychology classroom, AllPsych ON LINE)

Like Piaget, Erik Erikson (1902-1994) maintained that children develop in a predetermined order. Instead of focusing on cognitive development, however, he was interested in how children socialise and how this affects their sense of self. Erikson’s Theory of Psychosocial Development has eight distinct stages, each with two possible outcomes. According to the theory, successful completion of each stage results in a healthy personality and successful interactions with others. Failure to complete a stage successfully can result in a reduced ability to complete further stages and therefore, a more unhealthy personality and sense of self. These stages, however, can be resolved successfully at a later time.

Trust vs. Mistrust
From ages birth to one year, children begin to learn the ability to trust others based upon the consistency of their caregiver(s)’ relationship with them. If trust develops successfully, the child gains confidence and security in the world around him and is able to feel secure, even when threatened. Unsuccessful completion of this stage can result in an inability to trust and therefore a sense of fear about the inconsistency of the world. It may result in anxiety, heightened insecurities and an intense feeling of mistrust in regard to the world around them.
Autonomy vs. Shame and doubt
Between the ages of one and three, children begin to assert their independence by walking away from their mother, selecting which toy to play with and making choices about what they like to wear, to eat, etc. If children in this stage are encouraged and supported in their increased independence, they become more confident and secure in their own ability to survive in the world. If children are criticised, overly controlled, or not given the opportunity to assert themselves, they begin to feel inadequate in their ability to survive and may become overly dependent upon others, lack self-esteem and feel a sense of shame or doubt in their own abilities.

Initiative vs. Guilt
Around age three and continuing to age six, children assert themselves more frequently. They begin to plan activities, make up games and initiate activities with others. If allowed this opportunity, children develop a sense of initiative and feel secure in their ability to lead others and to make decisions. Conversely, if this tendency is suppressed, either through criticism or control, children develop a sense of guilt. They may feel like a nuisance to others and will therefore remain followers, lacking in self-initiative.

For the child to develop these stages, continuous parent-to-child communication must take place during routine activities, social activities and other daily activities, such as:
- Feeding times (talk to the baby/child about what they are eating, doing, etc.)
- Toilet routine (sing, talk, recite rhymes and smile at the baby/child during toilet training)
- Independent activities (talk to the baby/child when they are learning to do independent activities, i.e. brushing their teeth, bathing, combing their hair, tying their shoelaces, etc.)
- Creative physical activities (play games that require communication with the child)
- Story time and fantasy play (allow the child to engage in fantasy play and stories)
Module 10: Counselling and children

Aim of this module
Module 10 aims to guide the trainer on how to talk to children about HIV issues and death.

Learning outcomes

By the end of this module, the trainee should be able to:
✓ Demonstrate an understanding of the concepts of grief and loss and the associated feelings
✓ Apply the principles and process of talking to children about HIV issues and death.

Further reading
✓ *Elements of Counselling* by Joan Schon, Lauren Gower and Victor Kotze
10.1 What is counselling?

- Counselling is a process that happens between a child and caregiver that explores the trauma/incident that the child has experienced; it helps the child make sense of what has happened to him or her.
- It aims to assist the child to cope with their situation, emotions and feelings and helps them make positive choices and decisions.
- Counselling offers a safe place for the child to talk about sensitive and difficult issues.
- Counselling involves the helping skills of caring, listening and prompting. It is based on talking, listening and the respectful, trusting relationship that is built up between the caregiver and the child.
- Counselling helps the child to draw on their own resources to enable them to approach their problems and situation in a fresh and more effective way.
- Counselling is a process which assists the child to focus on their particular concerns.
- It supports the child to address and explore specific problems, make choices, manage crises, work through feelings of inner conflict and improve relationships with others.
- Counselling enables children to gain a better understanding of themselves and their situation, as well as help them develop strategies to manage change.
- Counselling must be treated confidentially between the authorised persons.

10.2 Situations in which a child may need counselling

Situations in which a child may need counselling include:

- Direct exposure to disaster
- Suffered personal loss due to divorce/separation of a parent/guardian, the death of a loved one, close friend or pet, or serious injury to a family member or friend
- HIV-related issues and testing
- Bereavement counselling
- Suspected sexual abuse
- Other forms of emotional or physical distress, i.e. anxiety, relationship problems or bullying
- Ongoing stress from their current situation
- Major behavioural changes
- Personal problems
- Developmental changes.
10.3 Principles of counselling

**Principles of counselling include:**
- Establishing a relationship with the child
- Helping the child tell their story using communication skills, e.g. questioning, probing, summarising, etc.
- Listening carefully
- Providing correct information
- Helping the child make informed decisions
- Helping the child recognise and build on their strengths
- Helping the child develop a positive attitude to life.

**It does not include:**
- Making decisions for the child
- Judging the child
- Interrogating, blaming, preaching, lecturing or arguing with the child
- Making promises that you cannot keep
- Imposing beliefs on the child.

10.4 Physical comfort of the child living with HIV and AIDS

When working with children living with HIV and AIDS, remember to first assess the child’s physical state of health before showing physical comfort to the child. You can show physical comfort in the following ways:
- Smile
- Rock the baby or young child in your arms
- Gently stroke or touch the child
- Hug or gently rub the child’s back
- Gently hold the child
- Gently brush the child’s hair
- Sing to the child and read/tell them stories
- Give them a cuddle when you tuck them into bed.

In order to provide comfort to children living with HIV and AIDS, it is important to meet their physical needs as well. The change from curing to caring means providing comfort to the child with the least invasive procedures, while maintaining his or her privacy and dignity. A terminally ill child has many of the same needs as any seriously ill child, including the following:

**A routine for sleep and rest**
Lack of sleep may be caused by discomfort, fear of not waking up, restlessness, or day/night confusion. Keep a night light on or a bell/intercom available so your child will know where he or she is if awakened and confused.
**Nutritional considerations**
Nausea, vomiting, diarrhoea and reduced eating are often associated with the effects of treatment and the progression of the disease. High-protein shakes may be an option if the child is only able to eat or drink small amounts.

**Changes in elimination**
Changes in elimination may also occur with a seriously ill or dying child. Diarrhoea, constipation and incontinence are all possible. Care should be given to provide the child with a clean environment. It is also important not to embarrass or humiliate a child that has recently become incontinent (unable to control the bowel or bladder).

**Skin care**
Skin care may also be a concern for the child living with HIV and AIDS. Nutritional status, elimination problems and immobility can all cause skin breakdown and/or pain. Infection may likely occur in this situation. The decision to use antibiotics can be discussed with the doctor.

**Fever**
Fever may be a source of discomfort. Medications that reduce fever, such as acetaminophen, may be given for comfort.

**Respiratory changes**
Respiratory changes may occur from pneumonia, narcotics or the progression of the disease. Often, the child will feel they are unable to catch their breath. Air hunger, as this is often called, can be frightening for the child. Decreased oxygen in the bloodstream may also cause the child to have a seizure. Oxygen supplied through the nose or by a mask may be needed simply for comfort.

**Nasal symptoms**
Secretions from the nose, mouth and throat may be difficult to manage in children living with HIV and AIDS. Suction devices are available, or simply repositioning the child may help drain the excess secretions.

**Pain management**
Pain management is an important concern for children living with HIV and AIDS. In a child that is dying, one of the greatest fears is pain. Every measure should be taken to eliminate pain.

Pain control options and management plans should be discussed before the child experiences significant pain. Fear of addiction to narcotics is common among families. It is important to understand, however, that the ultimate goal is comfort which means taking appropriate measures to assure the child is free from pain.

Pain may be acute or chronic. Acute pain is severe and lasts a relatively short time. It is usually a signal that body tissue is being injured in some way, and the pain generally disappears when the injury heals. Chronic pain may range from mild to severe, and is present to some degree for long periods of time. Medicating pain before it becomes too severe is advised. If pain medication is not given for a long period of time, it may not be as helpful. Pain may occur as a result of the illness or for other reasons. Children normally have headaches, general discomfort, pains and muscle strains as part of being a child. Not every pain a child expresses is a result of the illness.
Treatment for pain

Specific treatment for pain will be determined by your child’s physician based on the following:
- The child’s age, overall health and medical history
- Type of illness
- Extent of disease
- Discussion of treatment options
- The child’s tolerance for specific medications, procedures or therapies
- Your opinion or preference.

10.5 The sexually assaulted child

Although these signs do not necessarily indicate that a child has been abused, they may help adults recognize that something is wrong. The possibility of abuse should be investigated if a child shows a number or any of these symptoms to a marked degree:

Sexual abuse
- Being overly affectionate or knowledgeable in a sexual way inappropriate to the child’s age
- Medical problems such as chronic itching, pain in the genitals, venereal diseases
- Other extreme reactions such as depression, self-mutilation, suicide attempts, running away, overdoses, anorexia
- Personality changes such as becoming insecure or clingy
- Regressing to younger behaviour patterns such as thumb sucking or bringing out discarded cuddly toys
- Sudden loss of appetite or compulsive eating
- Being isolated or withdrawn
- Inability to concentrate
- Lack of trust or fear of someone they know well, such as not wanting to be alone with a babysitter or child minder
- Starting to wet again (day or night), nightmares
- Become worried about clothing being removed
- Suddenly drawing sexually explicit pictures
- Trying to be ‘ultra-good’ or perfect, over-reacting to criticism.

Physical abuse
- Unexplained recurrent injuries or burns
- Improbable excuses or refusal to explain injuries
- Wearing clothes to cover injuries, even in hot weather
- Refusal to undress for gym
- Bald patches
- Chronic running away
- Fear of medical help or examination
- Self-destructive tendencies
- Aggression towards others
- Fear of physical contact, shrinking back if touched
- Admitting that they are punished, but the punishment is excessive (such as being beaten every night to ‘make him study’)
- Fear of suspected abuser being contacted.
Emotional abuse

- Physical, mental and emotional development lags
- Sudden speech disorders
- Continual self-depreciation (‘I’m stupid/ugly/worthless, etc.’)
- Overreaction to mistakes
- Extreme fear of any new situation
- Inappropriate response to pain (‘I deserve this’)
- Neurotic behaviour (rocking, hair twisting, self-mutilation, etc.)
- Extremes of passivity or aggression.

Note: A child may be subjected to a combination of different kinds of abuse. It is also possible that a child may show no outward signs and hide what is happening from everyone.

Suspected abuse

If you suspect that a child is being abused, seek advice from your supervisor. Knowing how damaging abuse is to a child, it is up to the adults around them to take responsibility for stopping it.

If a child tells you about abuse:
- Stay calm and be reassuring.
- Find a quiet place to talk.
- Believe in what you are being told.
- Listen, but do not press for information.
- Say that you are glad that the child told you.
- If it will help the child to cope, say that the abuser has a problem.
- Say that you will do your best to protect and support the child.
- If necessary, seek medical help and contact the police or social services.
- If your child has told another adult such as a teacher or school nurse, contact them. Their advice may make it easier to help your child.
- Determine if this incident may affect how your child reacts at school. It may be advisable to liaise with you child’s teacher, school nurse or head teacher.
- Acknowledge that your child may have angry, sad or even guilty feelings about what happened, but stress that the abuse was not the child’s fault. Acknowledge that you will probably need help dealing with your own feelings.

10.6 Things to consider when counselling the child

If a caregiver wishes to counsel a child, they first need to establish a relationship with the child. A child under five will need different techniques to an older child.

When counselling the child, consider the following:
- Their age
- Their psychosocial maturity
- Their cognitive development (ability to understand)
- The complexity of their family dynamics
- Their physical and emotional state
- Their past experiences
- Their religious and cultural beliefs
- Their readiness for help.
The following techniques can be used when counselling the child:
- Reading or telling stories, i.e. puppet shows, role play, flannel boards, story books, toys, etc.
- Doing creative activities, i.e. painting, drawing, colouring-in activities, modelling with clay, etc.
- Showing flash cards for conveying information.
- Playing board games or other games.
- Completing physical activities and games.

10.7 What caregivers can do to help the child

As a caregiver, there will be times when you will have to conduct planned or unplanned counselling.

Planned counselling can be:
- At a set date, time and place using pre-planned activities and conducted by specific caregivers
- In a structured environment (private with no barriers or interruptions)
- Recorded.

Unplanned counselling can be:
- At any time with no set date, time, place, specific caregivers and activities
- In an unstructured environment (i.e. during play time, bath time, meal time, outings, etc.)
- Not recorded immediately but informal notes could be jotted down afterwards.

Steps to counselling the child:
- Remain calm, approachable, confident and in control.
- Let the child feel at ease.
- Encourage the child to talk, draw pictures or tell their story in a manner that is comfortable to them. You can start off with something like: "It seems that you are not your normal cheerful self today. Would you like to tell me how you are feeling?" Sometimes the child will tell you how they are feeling or what has made them feel the way that they do without you having to ask them.
- Use age-appropriate language (i.e. language that the child uses and understands for their particular age).
- Work from their feelings and ask them probing questions. You can also ask questions like: "What makes you feel happy/sad/scared/angry?" etc.
- Use open-ended questions (i.e. questions that require more than a yes or no answer).
- Be a good listener and use appropriate gestures and eye contact.
- If the child asks questions, answer as best as you can and be honest.
- Be prepared to repeat yourself as children need time to process and understand issues and events.
- Vary the words that you use and check that the child understands what you have said.
- Be supportive and help the child clarify their problems.
- Don’t let the counselling sessions carry on too long as the child will get tired. Normally 10-20 minutes is sufficient depending on the age and developmental level of the child. Use the child as a guideline to see when to end the session.
- Wrap up the session by summarising the important issues discussed and reassure the child that you are there for them if they want to talk again.
10.8 Activity – Process of counselling children

Aim: To practise counselling skills

Trainer’s instructions
- Give the trainees a counselling scenario.
- One trainee must role play being the counsellor, one the child and one the observer.
- Explain to the trainees that you will also observe the counselling process and use the observation sheet to make notes.
- Afterwards you will discuss the observations you recorded.
- The feedback form is included for the caregiver to use after they have counselled the child. The caregiver must complete it and give feedback to the large group.

Scenario
Anna is a four-year-old girl living with HIV and AIDS. She has displayed some changes in behaviour, i.e. refusing to play with her friends. Her mother usually visits her every second week but was unable to visit her last week due to her own illness caused by her HIV status.

You are Anna’s caregiver and during her bath routine, you have noticed that she refuses to get into the bath and just sits on the floor crying.

Do a skills practice demonstrating an unplanned counselling session how you will deal with this situation.
## 10.9 Observation feedback on role play

<table>
<thead>
<tr>
<th>Criteria to observe</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the caregiver calm, confident and in control?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver make the child feel at ease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain your answer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver encourage the child to talk and tell their story?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain your answer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver use probing and open-ended questions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver use age-appropriate language?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If not, give examples:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the caregiver a good listener?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver use appropriate eye contact and gestures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain your answer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the caregiver supportive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver clarify the child’s problem?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give examples:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver wrap up the session by summarising important issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain your answer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the caregiver reassure the child and order continuous support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Give examples:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General observations:**
## 10.10 Counselling session feedback

Sample form for caregiver to use after the counselling session; modify as needed

<table>
<thead>
<tr>
<th>Name of child:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth of child:</td>
<td></td>
</tr>
<tr>
<td>Name of caregiver:</td>
<td></td>
</tr>
<tr>
<td>Date of counselling session:</td>
<td></td>
</tr>
<tr>
<td>Time of counselling session:</td>
<td></td>
</tr>
</tbody>
</table>

**Reasons for counselling the child:**

**Behaviour of child:**

**Issues that came up during the counselling session:**

**Action plan:**

**For the next session I will need:**
Bibliography


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**Glossary**

**Acute pain**
Acute pain is severe and lasts a relatively short time. It is usually a signal that body tissue is being injured in some way and the pain generally disappears when the injury heals.

**Adherence**
Sticking to treatment plan.

**AIDS**
Acquired Immune Deficiency Syndrome.

**AIDS-related dementia**
Mental confusion because of HIV virus attacking the brain cells.

**ART**
Antiretroviral treatment against the HIV virus.

**CBO**
Community based organisation.

**CD4 count**
The number of CD4 cells in the blood.

**Chronic pain**
Chronic pain may range from mild to severe and is present to some degree for long periods of time.

**Confidentiality**
Confirming knowledge on a need-to-know basis.

**Counselling**
Counselling involves the helping skills of caring, listening and prompting. It is based on talking and listening, and the respectful, trusting relationship that is built up between the caregiver and the child.

**Developmental milestones**
Progression of development defined in terms of age.

**Developmental programme**
A programme designed to assist children in reaching their developmental milestones.

**Discrimination**
Treating people differently or unfairly.

**Elimination**
Is the process whereby a substance or other material is expelled from the body usually by a process of extrusion or exclusion but sometimes through metabolic transformation. The combination of chemical degradation of a xenobiotic in the body and excretion by the intestine, kidneys, lungs, skin, in sweat, expired air, milk, semen, menstrual fluid or secreted fluids.

**Enzyme**
A substance that assists chemical processes.

**HIV**
Human Immune Virus.

**NGO**
Non-governmental organisation.

**Parentified child**
A child who has assumed the role of the parent in a family. This occurs when the parent is unable to fulfil the role due to illness, prolonged absence or psychological problems.

**Nutritional status**
Is a global term that refers to nutritional screening, nutritional assessment, nutritional care and nutritional support.
Pain management  Surgery, procedure or other treatment designed to reduce pain and help the patient achieve a reasonable quality of life and ability to function

PLWA  People living with HIV and AIDS

Sexual abuse  Abuse of a sexual nature such as rape, incest, fondling and indecent exposure. Sexual abuse can cause various physical and emotional problems including lack of self-esteem, self-destructive behaviour, anxiety and depression

STI  Sexually transmitted infections

Stigmatisation  A mark of disgrace

TB  Tuberculosis

Viral load  Amount of virus in the blood